provided to beneficiaries of title XVIII of the Federal Social Security Act and excluding direct medical education costs.

(b) [~~$33 million shall be allocated for technology advances and changes in medical practice. Amounts allocated to each general hospital shall be based on a fixed amount per bed determined by multiplying the number of certified inpatient beds for each general hospital as of June 30, 1990 by the result of dividing the $33 million by the sum of the certified inpatient beds for all general hospitals.~~]

(c) $26 million shall be allocated to costs of general hospitals based on the costs incurred in excess of the trend factor between 1985 and 1989 in the following discrete areas: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast media, malpractice costs, water and sewer charges, ambulance costs, service contracts, prosthetic and orthotic devices and costs related to designation as a trauma center and contracted nursing services.

(1) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for each discrete area for all general hospitals is greater than or equal to $26 million, the $26 million shall be allocated to costs of general hospitals based on the ratio of each general hospital's 1989 costs incurred in excess of the trend factor in such discrete areas, summed, to the total sum of such cost over trend of all general hospitals.

(2) If the 1989 costs incurred in excess of the trend factor between 1985 and 1989 summed for all general hospitals is less than $26 million, the allocated costs to each general hospital

(DRGs) 475,483,540, 701-716 and 798-801.

(b) $63 million shall be allocated to general hospitals for labor adjustments. Such amount shall be allocated as follows:

(1) An amount equal to $55 million shall be allocated for labor cost increases incurred prior to June 30, 1993. Amounts allocated to each general hospital shall be based on the general hospital's share of the statewide total of inpatient and outpatient reimbursable operating costs based on 1990 data excluding costs related to inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54 (g) (3);

(2) An amount equal to $8 million shall be allocated for labor adjustments to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each general hospital determined pursuant to this subclause shall receive a portion of the $8 million equal to the general hospital's portion of the total inpatient and outpatient reimbursable operating costs based on 1990 data for all hospitals located in the counties identified pursuant to this subclause, excluding costs related to services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) and excluding direct medical education costs, as determined pursuant to section 86-1.54(g)(3).

(c) [~~$55 million shall be allocated for increased activities related to regulatory compliance universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which each hospital is certified as of August 24, 1993.~~]

(d) An amount equal to $3 million shall be allocated to the costs of each general hospital in the following manner and which meet the following criteria:

(1) $250 per bed shall be allocated to the costs of each general hospital having less than 201 certified acute care beds as of August 24, 1993 and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the Federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (D) or defined by Federal law (see 42 U.S.C. section 1395 ww(d) (2) (d) or defined as a rural hospital under section 700.2 (a) (21) of

other payments specified elsewhere in this section if the patient is a transfer patient as defined in section 86-1.50(j) of this Subpart.

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to all DRG case-based rates of payment calculated pursuant to paragraph (1) of this subdivision, and to rates or supplemental payments made pursuant to paragraph (3) of this subdivision.

(i) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(ii) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) For the period July 1, 1995 through June 30, 1996 the Commissioner shall increase the rate of payment, in the aggregate by an amount not to exceed seventy-five million dollars for those voluntary non-profit and private proprietary general hospitals which qualify for distributions as a financially distressed hospital pursuant to section 86-1.66 of this Subpart and that requested designation as such before February 1, 1995 or qualify for the supplementary low income patient adjustment in accordance with section 86-1.84 of this Subpart. The rates will be increased as follows:

(i) $18.75 million shall be allocated among such hospitals which have an outstanding debt obligation to the New York State medical care facilities finance agency or its successor, as an eligible secured hospital borrower and any hospitals which qualify for distributions as financially distressed hospitals in accordance with section 86-1.66 of this Subpart with a negative fund balance in excess of $50 million dollars as of December 31, 1994, based on the estimated proportionate impact for each such hospital compared to all such hospitals of the reductions in payments by state governmental agencies for hospital inpatient services through June 30, 1996, as contained in a chapter of the laws of 1995, specifically New York State's Public Health Law, enacting cost containment provisions for the Medical assistance program.

program. Any remaining amount not allocated by March 31, 1996 according to this subparagraph shall be allocated according to clause (c) of subparagraph (ii) of this subdivision.

(iv) Allocations pursuant to this subdivision shall be based on general hospital classifications as of April 1, 1995.

(b) Exempt hospitals and units. Payments to hospitals for acute care services that are exempt from DRG case-based payment rates shall be established pursuant to section 86-1.57 of this Subpart. The hospital specific costs identified in subparagraph (a)(1)(ii) of this section shall be apportioned to the exempt unit operating per diem based on the data provided by the hospital. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(1) For the period April 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(2) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58

(c) Alternative level of care payments. Hospitals providing alternative level of care services as defined in section 86-1.50 of this Subpart shall be reimbursed for this care pursuant to the provisions of section 86-1.56 of this Subpart. [~~These payments shall include a health care services allowance~~]

(1) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, [~~rate year~~] 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(2) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(3) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

86-1.54 Development of DRG case-based rates of payment per discharge. (a) The hospital-specific average reimbursable inpatient operating cost per discharge shall be determined by dividing hospital-specific non-Medicare reimbursable operating costs determined pursuant to paragraph (1) of this subdivision by non-Medicare discharges determined pursuant to paragraph (2) of this subdivision and dividing this result by the hospital-specific case mix index determined pursuant to paragraph (3) of this subdivision.

(1) Hospital-specific non-Medicare reimbursable operating costs shall be the hospital's 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart including any adjustments made pursuant to section 86-1.52(a)(1)(iii)(a)(iv), and (v) of this Subpart but excluding the following costs:

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) transfer costs as defined in subdivision (f) of this section;

(v) short-stay outlier costs as defined in subdivision (f) of this section; and

(vi) high-cost outlier costs as defined in subdivision (f) of this section.

(vii) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, such administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph, shall mean those base year administrative and general costs remaining after application of all other efficiency standards,

to paragraph (a)(3) of this section. The group average wage and case mix adjusted operating cost per discharge shall be based on hospital-specific reimbursable operating costs which shall be calculated as follows:

(1) The following costs shall be subtracted from the sum of the hospital's allowable 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this subpart and any adjustments made pursuant to section 86-1.52 (a)(1)(iii)(a), (iv), and (v)(a).

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) direct GME costs as defined in subdivision (g) of this section; and

(v) hospital-specific operating costs as defined in subdivision (g) of this section.

(vi) For rates of payment for discharges occurring on or after April 1, 1995 through March 31, 1999 the reimbursable base year inpatient administrative and general costs of a general hospital shall include reported administrative and general data, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs. Excluding providers reimbursed on an initial budget basis, administrative and general costs shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. This limitation shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the Commissioner for each general hospital. Reimbursable base year administrative and general costs, for purposes of this paragraph shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines.

(2) The hospital-specific portion of the $40 million base enhancement specified in section 86-1.52(a)(1)(iii)(b) of this Subpart shall be added to the costs determined for each hospital in

Section 86-1.55

Development of Outlier Rates of Payment.

(a) Short Stay Outliers. Payments for short stay outlier days shall be made at a per diem calculated by multiplying the days of actual length of stay below the short stay threshold by the short stay per diem rates defined in this subdivision. The short stay per diem rate shall be determined by dividing the hospital's DRG case-based rate of payment determined pursuant to section 86-1.52(a)(1) by the hospital's group average arithmetic inlier LOS for the DRG and multiplying the result by the short stay adjustment factor of [~~150~~] [100] percent. In cases where the group average arithmetic inlier length of stay for the DRG is equal to one, the short stay adjustment factor shall not be applied. Budgeted capital costs determined pursuant to section 86-1.59 of this Subpart shall be added to the per diem.

(b) Long stay outliers. Payments for long stay outlier days shall be made at a per diem rate calculated by multiplying the days of the actual length of stay in excess of the long stay outlier threshold by [~~60~~] [50] percent of the per diem obtained by dividing the group average DRG operating cost per discharge defined in section 86-1..54 (b) of this Subpart by the hospital's group average arithmetic inlier length of stay for the DRG. This result shall be multiplied by the percent for the group average reimbursable inpatient operating cost determined pursuant to section 86-1.53 of this Subpart. These payments shall include a health care services allowance of .614 percent for rate year 1994 and .637 percent of the rate year 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Cost outliers. (1) Cost outlier payments must be requested from the third-party payor.

86-1.54, of the difference between such cost, and the greater of two times the hospital's diagnosis related group case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1)-(2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(1) of this Subpart or six times the hospital's average DRG case-based rate of payment for the patient as calculated pursuant to paragraphs (a)(1) and (2) of section 86-1.52 of this Subpart, subsequent to the elimination of all prospective adjustments which reflect a retroactive impact of an adjustment in accordance with section 86-1.61(1) of this Subpart.

(3) Cost outlier payments shall not be made for cases that qualify as short stay outliers or transfers (other than patients assigned to transfer DRGs). Patients assigned to transfer DRGs may meet the criteria for outlier payments, in which case the limitations set forth in this paragraph shall apply. If during a rate year the payments for high-cost patients made pursuant to this subdivision reach the proportion of high costs calculated pursuant to section 86-1.54(f)(3) of this Subpart, then all additional requested high-cost payments for that rate year, including the inlier DRG case payment rate, shall be pended until the appropriateness of the charge schedule upon which the high costs are determined is reviewed.

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for **the period January 1, 1995 through June 30, 1995** [~~rate year~~] of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to the cost outlier payments.

**(i) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and**

**(ii) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.**

(5) Hospitals that have not established ancillary and routine charges schedules shall not be eligible for high-cost outlier payments.

to section 86-1.58 of this Subpart. A capital per diem payment shall be computed on the basis of allowable budgeted capital costs allocated to the unit divided by budgeted days in the unit, reconciled to actual certified capital expense divided by actual days. A [~~primary~~] health care services allowance of:

(1) .614 percent [~~of the hospital's non-Medicare reimbursable inpatient costs~~] for rate year 1994 and .637 percent for [~~rate year~~] the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58;

(2) for the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(3) for the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58 shall be added to the rate. AIDS Centers that do not comply with the provisions of Part 405 of this Title with regard to the provision of inpatient, outpatient community and support services for the screening, diagnosis, treatment, care and follow-up of patients with AIDS shall have their rates of payment prospectively adjusted to reflect services not being provided in accordance with Part 405 of this Title from the time the services were not being provided in accordance with Part 405 of this Title.

86-1.58(6/95)
Attachment 4.19-A
Part I

86-1.58 Trend Factor. (a) The commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of section 86-1.52 of this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provisions of this section.

(b) The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner.

(c) The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.

(d) The commissioner shall implement one prospective interim annual adjustment to the trend factors, based on recommendations of the panel, effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors based on recommendations of the panel to be effective on January first, two years after the initial trend factor was established. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.

(e) Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 to December 31, 1995 rate period for purposes of projecting allowable operating costs to subsequent rate periods.

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86-1.59 Capital expense reimbursement for DRG case based rates of payment. Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall, with the exception noted in **subdivisions** (c), **(g) and (h)** of this section, be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1-24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart. In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period. **For rates commencing April 1, 1995, if a factor for the reconciliation of budgeted to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such component shall be reduced by the difference between the applicable reconciled capital related inpatient expenses for such prior year, and capital related inpatient expenses for such prior year calculated based on a determination of costs related to services provided to beneficiaries of the Title XVIII federal social security act (Medicare) based on the hospital's average capital related inpatient expenses computed on a per diem basis.**

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of

transferred out patient days and which shall be reconciled to actual rate year days) and the non-exempt hospital's average budgeted capital cost per day calculated using total non-exempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the non-exempt hospital in the rate year after these data are available based upon the on-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined [by applying the relationship of Medicare ancillary charges to total ancillary times total inpatient ancillary capital costs] based upon the hospital's average capital related inpatient per diem. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital, adjusted for secondary payors.

(3) Allocation of payments for transfer patients and short-stay patients. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated non-exempt unit on-Medicare days reconciled to actual rate year days.

(f) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the allocated non-Medicare capital costs identified in paragraph (e)(1) of this section by the 1985 exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital approved capital expense.

(2) Capital payments for DRG case-based rates shall be determined by dividing the budgeted capital allocated to such rates by the hospital's most recently available annual non-Medicare, non-exempt unit discharges, reconciled to rate year discharges

For the rate period July 1, 1994 through December 31, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis when taking into consideration the rate of growth between the 1992 and 1987 rate years, six and two tenths percent from the adjusted 1992 non-Medicare statewide average reported case mix for 1994. For [~~rate years commencing~~] the rate period January 1, 1995 through March 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare Statewide average case mix [~~for 1995~~]. For the rate period April 1, 1995 through December 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, two percent [~~and an additional one percent per year thereafter~~] from the 1992 non-Medicare statewide average reported case mix. For the rate period January 1, 1996 through June 30, 1996, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare statewide average reported case mix. The maximum allowable increase shall be applied to adjust rates of payment for the periods commencing January 1, 1990 and thereafter, using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter except for the period January 1, 1994 through December 31, [~~1994~~] 1995 as noted above; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basic malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to section 86-1.63 of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year case mix index determined pursuant to paragraph (4) of subdivision (b) of section 86-1.75 by the statewide base year case mix index determined pursuant to paragraph (2) of subdivision (b) of section 86-1.75 and subtracting one from the result.

statewide average capital cost per day for comparable exempt hospitals divided by exempt hospital patient days reconciled to actual total expense; and

(3) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(4) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(5) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Comprehensive Cancer Center Specialty Rates of Payment.

(1) Bone Marrow transplantation services provided in exempt comprehensive cancer centers shall be reimbursed, upon the request of a comprehensive cancer center therefore, on the basis of a separate per diem rate composed of:

(i)(a) An initial per diem operating cost component computed on the basis of allowable historical inpatient bone marrow transplantation operating expenses based on separately identifiable base year cost and statistical data for the bone marrow transplant unit. The base year Medicare share of these costs shall be removed in accordance with paragraph (a)(5) of this section. The non-Medicare exempt bone marrow transplant operating cost component shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base year to the rate year using total reimbursable non-Medicare costs and statistics of the bone marrow transplant unit pursuant to section 86-1.64 of this Subpart. In the event that the bone marrow transplant unit is established subsequent to the comprehensive cancer hospital's base year, the initial per diem operating cost component shall be computed on the basis of separately identifiable budgeted costs and statistical data and subsequently adjusted to actual costs.

(b) The per diem rate shall be further adjusted to reflect costs incurred subsequent to the base year but not reflected in such base which are approved pursuant to section 86-1.61 of this Subpart.

(ii) A capital per diem cost component computed on the basis of budgeted capital costs allocated to the bone marrow transplantation unit, pursuant to the provisions of section 86-1.59 of this Subpart divided by the bone marrow transplantation unit patient days reconciled to actual total expense; and